View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by University of Nebraska Medical Center Research: DigitalCommons@UNMC

University of Nebraska Medical Center

DigitalCommons@UNMC

MD Theses

Special Collections

5-1-1941

Problems and trends in medical care : the indigent

Verne V. Alder
University of Nebraska Medical Center

This manuscript is historical in nature and may not reflect current medical research and practice. Search PubMed for current research.

Follow this and additional works at: https://digitalcommons.unmc.edu/mdtheses

 Part of the Medical Education Commons

Recommended Citation

Alder, Verne V., "Problems and trends in medical care : the indigent" (1941). *MD Theses*. 838.
https://digitalcommons.unmc.edu/mdtheses/838

This Thesis is brought to you for free and open access by the Special Collections at DigitalCommons@UNMC. It has been accepted for inclusion in MD Theses by an authorized administrator of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.

PROBLEMS AND TRENDS IN MEDICAL CARE; THE INDIGENT.

Verne H. Alder

Senior Thesis presented to the University of Neb.
College of Medicine
1941

INTRODUCTION

In recent years there has been a definite social trend which has resulted somewhat in conflict between the traditions of the medical profession and the new social attitude. This new social attitude is very real, and is certainly something which cannot be ignored or combatted in any manner but a judicious and far-seeing one as far as the medical profession is concerned.

It is important to analyze the present attitude of the public with regard to medical services in the attempt to more thoroughly understand the clashes, controversies, and serious implications that have arisen in the last few years. Certainly a review of medical practices and changes within the last forty years will not be amiss at this time.

There was once a time when the service of doctors in the matter of health and sickness was regarded from an individualistic standpoint. With but few exceptions---namely that of epidemics of widespread nature---there was scarcely a conception of health problems and services as we see them today. The attitude, needless to say, was a result of our isolated method of living and the earlier "individual" philosophy.

In the more recent years, several factors stand out which have had much to do with our present concept and attitude.

481202

Since the turn of the century, the methods of travel have diminished distance and made easier the transmission of disease to wider areas. To meet this problem, the government-operated Public Health Service made certain steps, and effectively, in the field of preventative medicine as well as immunization.

More recently there has been the developement of public health work in the schools. This work began at its earliest during the close of the last century and has become more and more widespread since that time. It was developed mainly as a community responsibility for the prevention, as nearly as possible, the spread of communicable diseases. At this time, it became evident to the physicians as well as the educators that certain children were ineffective in their work in school, and that a correction of their physical defects, if possible, would result in more efficient performances of the child. This lead to the physical examination of the school children with the idea of improving their condition so that they might receive full benefit from the educational facilities given to them. The physical examination has been followed by a systematic immunization for communicable diseases, sanitation measures for the further safety of the children, and has progressed to the level now, where even the nutrition of the child can almost be guaranteed satisfactory. Today this work is an integral part of our school system. In brief, there has evolved an entire generation that has been educated to the idea of a free and reasonably adequate health service.

This is one link in the chain of changing social attitudes.

Along in 1917-18, a large number of these individuals already accustomed to health services joined the army. Here their health needs were taken care of without thought of compensation to the physician rendering the service. This service was gratis and came to be expected. Not only this, but the service was rather effective in the prevention of many communicable diseases, and the army and navy came to be looked upon, and rightly so, as an example of good public health measures. This makes the second link in the chain.(1)

Finally, when the boys were released from the army and were demobilized, they returned to industry which now became a donor of medical care to its employees. For example, in 1935, the United States Steel Corporation employed 335 company surgeons, physicians, and interns, 117 "outside" physicians, 61 visiting nurses, 351 nurses, and 40 sanitation inspectors, and this is but one company. Thus, those who had become trained to the acceptance of health service in school and in the army came now to the acceptance of medical care incident to employment.(1)

Then, too, the government became aware of the disabilities of the veterans and provided free hospitalization for them along with the necessary medical services. It was not long before these benefits were extended to all those service men who had had an honorable discharge.

Governmental participation in medicine, however,

is not entirely confined to the veterans. It now includes some 25 agencies, the most important of which includes the state and city health departments. There is a rapid increase in the number of federal, state, county, and city operated hospitals for tuberculosis, mental diseases, and cancer. Few people can realize to what extent hospitalization has been provided for by the government agencies. In 1931, for example, 73% of hospital service was provided for by the government. Lastly, one must mention the more recent of these agencies in the F.E.R.A., the Social Securities Act, the Sheppard-Towner Act, and the Chamberlain-Kahn Act. These are all evidences of governmental interest in public health. (1)

Along with this advance of the government into fields of medicine, privately practiced medicine has made rapid strides, too. Since the turn of the century, educational facilities have been developed in this country to such an extent that Vienna, Germany, and England no longer attract the attention of the physicians of this country as they previously did. Free enterprise has been permitted here. Over there the government has extended its zone of power too widely and has throttled a formerly efficient system. As will be shown later in this paper, our system has, during this period, become to be recognized as one of the better methods of dealing out medical services. Statistically, this is borne out by the reduced mortality and morbidity rates as compared with those countries not having a system such as ours and with comparable circumstances as to population and location.

With the evolution as outlined above, one can scarcely wonder why the present complex problems as pertaining to the dispensing of medical services has arisen. On the one hand, we have those people educated by the medical profession to demand an increasingly greater amount of medical service, and on the other hand, at the present time, we have more and more people less able to pay because of a variety of reasons, most of which are economic. What, then, shall be the change, for there may be a change. Shall the medical profession combat this new philosophy to the bitter end and risk being engulfed by it and pushed into what it knows to be an inadequate system, or shall it wisely and far-sightedly guide the line of thought away from the channels into those in which there is but little fundemental change and yet which will aid in the solution, a real and permanent solution, of the problem.

This paper, as a discussion of care for the medical indigent, will deal in a small measure with the need for care in addition to several plans of giving medical service to all income groups. The need for the care of the medical indigent is not necessarily based on the premise that our present system is fundamentally unsound, but rather, with modifications the present system can be converted into a stronger argument against a socialization or conversion into a state controlled medicine. This stand should, logically, be taken because of the widespread social changes encountered today and their gradual encroachment into the practice of medicine. The text of the introduction can, therefore, stand as one of the reasons why careful thought should, and must, be given to the dispensing of medical services in the future.

Another important reason, at this time, is the fact that the indigent group is the largest that it has ever been. There are now about five million families on relief receiving gratuitous medical care that is on higher level than they have been accustomed to receiving in the past. One wonders if these people will care to relinquish their position as long as they are able to vote and as long as politics is willing to make the most of the situation. It is not inconceivable that these people may desire to continue with a tax supported system of medical services. (3)

Then too, in this enormously enlarged group of medical indigents, illness is more frequent and lasts for a considerably longer period of time. For example, disabling and chronic diseases occur at a 57% higher rate in the families on relief than they do in the $3,000 income bracket. The illnesses that do occur in the relief families last 63% longer. (3) These statistics are not an indictment of the present system, nor are they caused by it, although some writers maintain that this shows a definite need for a change. It is here that socialization has one of its strongest footholds. Still another reason for the need of more "adequate" medical care, as pointed out by many writers, is the presence of numerous physical defects in the population as a whole. This fact, some point out, is emphasized by the amount of physical defects turned up by the draft. Another example of the prevalence of physical defects can be shown in a recent survey conducted in this state, in Howard County, in which 555 individuals were examined by a group of physicians (specialists) and technicians. It should be noted that the people studied in this survey were rural inhabitants who are receiving government loans and who can be classed as indigents. The board of experts found slightly more than two physical defects per person.(4) These physical defects ranged from dental caries to flat feet. It is not inconceivable that in the future, some writer may point to this fact and say that these people are entitled to care and that their care

as a preventative measure, will result in the ultimate saving of the increased cost of later and more serious illness.

Then too, in the impending world crisis, the goverment, with its "drafting"of business, may draft the medical profession for civilian care as well as for the army and navy. This is not beyond reason nor is the fact that this system may persist, beyond reason. It is also necessary, therefore, to make plans for the general population as well as the indigent.

Let us summarize, briefly, the more important reasons for a need. We find that the population has numerous physical defects. Large numbers of the population are without adequate financial means. These needs, while fundementally weak, combined with a social pressure and multiplied many fold by socially minded writers, have become not inconsequential. This, then, is the need.

In reviewing the literature on this topic, one is immediately impressed with the numerous fallacious viewpoints expressed. Sociologists, who have given up in their endeavors to correct the business world, have descended upon the physician and are laying their vast "knowledge" at his feet. Innumerable lay people have aired their views, made their surveys, and advocated changes in a tried and efficient system. The medical profession,

on the other hand, have taken but little time from their work, in fact too little time, to effectively combat the challenge.

Needless to say, it is necessary to correct some of the statements made by the proponents of radical change. An evaluation of some of the efforts of these social workers, sociologists and philanthropists follows;(5)

1. The surveys have, in the large numbers of cases, been conducted by individuals who are not able to diagnose illness and to determine the actual need for medical care. In a few cases, nurses were used for the gathering of statistics. In one case lay persons on relief assisted, and the time that each worker had to do his work was so cut down by regulations that it was impossible to have at least a moderate amount of training in the detection of illnesses or the need of care.

2. To avoid the need of expert opinions, in some cases standard definitions of diseases were used to secure some uniformity and standardization. These definitions were identical with absences from school or work or even to the purchases of drugs. It can be admitted that there is some correlation between these and illnesses, but they certainly are not identical. Diseases cannot be correlated in this way if real accuracy is desired.

3. Surveys have failed to show that the individual had any desire for medical care in the first place. No one has reported on the number of individuals who were ill and desired medical service but were unable to get it. Nobody makes any statements, true or false, concerning the number of individuals who were ill but were using patent medicines or preferred the attention of cults. There have been no findings on the severity of the disease and the necessity for medical care.

4. Most of the surveys were made with the idea of determining how many people were deprived of medical care. None of the surveys, however, made any attempt to show to what extent the lack of income was really responsible for the purported lack of medical care. Every one of the surveys completely ignores the fact that the ethics of the medical profession require the rendition of service whenever needed re-

gardless of remuneration.

The above statements are but a small portion of the criticism that can be made of literature opposing the present system. Many other discrepancies may be brought to light, however, when one reviews the morbidity and mortality rates of other countries with comparable locations but having a system of socialized medicine. These statistics are completely ignored except in those very few cases in which the statistics are more favorable to the other side. It must be remembered that these individuals are criticising a system that has a declining morbidity and mortality rate. For example since 1935 there has been a steady decrease in all diseases except Cancer, Diabetis, Cerebral Hemorrhage and Cardiac Diseases. (6) It must be remembered that these are diseases, in the great majority, of old age. The increase in this group simply means that the people are living to an older age and come into this group of diseases. Surely this is not caused by our present system of giving medical care. One writer in particular points out that the mortality in the older age group has not diminished in the last 50 years. She does not realize that there must be some age limit and that unless the life span keeps increasing, the mortality of the older age groups will increase. This same author states that she feels that the prevention of these chronic diseases can be better accomplished under a socialized system.(7)

Another prominent author has voiced the criticism that -- " - nor is there any prospect of any adequate action by the doctors collectively. The medical profession seeks even to prevent discussion of the subject. It has no adequate program of its own, and it condemns all programs of others." (8) One can readily see that this man is not as well informed as he pretends to be yet he criticizes rather freely. The medical profession has in the past and will in the future stand ready to adopt any methods or make any changes which will improve the quality of medical care as well as increase its scope. The medical profession recognizes, however, that the quality must not be sacrificed for a few cents' reduction in the cost of care.

The same author mentioned above ventures to say that since the people receive the medical care they should have a voice in saying how that care should be paid for. By the same sort of reasoning we would soon be telling the grocer or clothier just how much we should pay for our clothes and so forth and when we would pay for it. It doesn't take much farsightedness to see the chaos that would result if this chap had his way.

One point that almost all of the writers make the most of is the fact that economic conditions have a good deal to do with illness. We cannot argue here, but we can say that a carefully planned economic system would do almost as much as medicine in the illnesses

of this particular group. If the food, clothing and shelter were administered as well as the medicine it would not be long before there would be no quarrels.

The literature resolves itself into two separate lines of thought. One side sees all of the evils in the present system but cannot comprehend the evils which they support. The other, the medical profession, sees the evils of the new systems as well as evils in the present system. The medical profession feels that the evils of the new outweigh the faults of the old which can be corrected. Both sides seem to be sincere in the idea that those who need medical care and are unable to pay for it should have it regardless.

The body of this paper will be taken up by the discussion of plans for the giving of medical care. The indigent, as such, will not be considered directly, but it should be borne in mind that many of these systems are calculated to give the general public adequate care, and in so doing, remove from the near indigent group many who would likely become indigents. Thus, any plan, while not solving the indigent problem directly, may be useful in solving it indirectly.

To begin with, everyone seems agreed that the quality of medical service is without peer. Everyone agrees that there is a sufficient number of physicians, nurses, and others connected with medical services. When

one considers that the subsistence income is around $1300, and that the comfort level varies from $1500 to $3500, and that 53% of the non-farmers and 82% of the farmers fall in or below the $2000 wage level, the economic aspects of the problem assume large proportions. (9) Add to this fact that following one major illness in the family, the problem assumes even greater proportions. Let us say, now, that "Medical care is necessary for the maintenance of the health of the people, and should be provided for all the people who need it." (10)

The principle approaches to the problem of giving medical services to the general population may be outlined as follows: (11)

1. "----by undertaking no definite or planned social action, but trusting to a process of evolution and more or less casual experimentation." This is the situation at the present time. Several movements are now in process as evidenced by an increased prevalence of group payment of medical costs to the hospitals and physicians. There are now definitely expanding government facilities, both for the diagnosis and tthe treatment of illnesses with emphasis on preventative features. The tendencies of the physicians to think of groups is becoming manifest, and there is an increasing interest in improving the education of general practitioners with a view toward restoring the old "family" doctor to the central position. There is, too, a growing demand for the more effective control of specialization in the profession.

2. "----by the commercial organization of medicine and medical services on a large scale along lines similar to those on which public utilities and railroads have developed, namely, massed production by private interests and distribution at prices regulated by the public."

con't

3. "----by making all medical services a governmental function, either by gradual development of public medical services along lines fairly well established, or by some other revolutionary action. In either case, it would mean that all those who render these services would be employed by the public, and that all institutions and facilities for such services would be owned and operated by the public."

4. "----by applying the principle of compulsory insurance on a statewide or on a nationwide basis."

That, in brief, summarizes the possible methods of approach to the solution of the problem. The first solution is the method of today, and out of the conflicts of today will gradually be evolved a system that will be acceptable to a large number of people. The laissez-faire doctrine has a tendency to minimize the need for change, and recognizes, probably correctly, that the dangers of a new system outweigh existing evils.

The second approach seems to be inadequate and repugnant, and in view of the fact that business methods have, in the past, failed to solve other problems of rendering service, dampens ones enthusiasm for this solution. The real economic solution could not be accomplished with this system for the very simple reason that the majority of population would be unable to support a method such as this. Dr. John R. McNeal,M.D. states that the army medical service costs just double the average medical cost for this country. The Committee On Costs For Medical Care substantiated this when they found that army

medicine at Fort Benning cost $50.67 per person per year. This would be more than $200 a year for the average family of four. (12)

The third plan of action is at present at use in Russia. Public medicine of this kind is not regarded highly by a majority of persons, and although a few think that is may be the wisedt solutionm it is inconceivable that it can be operated for a long period of time in this country.

The last proposal, if put into effect on a larger scale than it now is in Great Britain, Japan, and in Europe, would still solve only a portion of the problem because it would of necessity include only those people able to pay the premiums which would be required for an adequate service. Thus, as in the second approach to the problem, the economic aspects of the plan would seem sufficient to make that plan untenable.

As to a solution---no one can conceivably be made to suffice. The problem involved seemingly call for a combination of medical services. Under our present economic system, those who can afford to pay will continue to do so. There are those poor, however, who are unable to pay, and to these, medical care must be given with a probability of increasing the amount of the services. This class at the present time is being served by a form of public medicine, and as the situation warrants, must be given more. (11) With this in mind, the only change in the present system, if it

can be called a universal change at the present time, seems to be the payment on an adequate basis of physicians for their service to the indigent. For the more expensive diseases such as Tuberculosis, Orthepedic defects, Cancer, etc., the public, in the case of the indigent and near indigent, should assume a greater responsibility. For the lower middle class who, for some reason or other, seems unable to budget satisfactorily for illnesses, a voluntary plan whereby small payments will insure medical services and hospitalization without impoverishing the individual, can be evolved by private insurance companies who have in the past insured almost anything. All this can be accomplished without any great change or without disturbing the principles and ethics of the medical profession as they stand today.

The problem thus resolves itself into caring for the person on relief and in caring for the person in the lower subsistence levels. Public medicine, such as we have today, is necessary for the charity case, while the other group must be offered some plan by which it can pay for the "catastrophic" illness. While the burden of care of the indigent, resting now on the physician, can be removed, the problem of the other group is more difficult to solve. This last group is the one which can budget all, or most of, the luxuries of life, but fails utterly to budget successfully for medical care which it so sorely needs sooner or later. In this lower income group, will be found a large percentage of illnesses which are reported in the surveys.

In this group lies one of the most difficult, if not the most difficult, problem of all. So in discussion of plans, let us keep this group in mind while the care if the indigent is promulgated.

To come to more specific measures in the care of the individual on relief, let us review what has been done in the past few years. The basis of care, of course, has been the physician as an individual who sees the patient, treats him, and writes him off the books as unable to pay a fee. The physician looks upon this as his obligation to society. In case of needed hospitalization, the patient may seek admittance to a tax supported institution or, failing this, he seeks to enter a private hospital at reduced rates. The rural patients have in the past had a more difficult time to get hospitalization. In the larger cities,too, free clinics for the care of the indigent are more numerous and more readily accessible, especially in those cities in which medical schools are located. There are also patients who are not able to purchase medicines needed for treatment, and in these cases difficulties arise in the treatment. Thus we see that the rural patients, indigents, do not have the efficient setup that the urban indigent has, and it is here that more planning should be done to increase facilities.

One of the recent attempts by the government to aid the indigent sick was the Federal Emergency Relief Administration. This plan was of a voluntary nature to be

worked out by the individual states on a basis which seemed suitable to that particular locality. The government was merely to supply funds and administrative details, while the physician was to administer service to the indigent on a fee basis worked out by agreement with the local government. It goes without saying that this system was viewed as an entering wedge for socialized medicine. It was, however, quite generally adopted although many physicians preferred to carry on without "help" from the government. As in all new systems, many difficulties were encountered, some of which are inherent in a system such as this, while others are inherent in human nature. This system has gradually disappeared, and in many localities has been replaced by a similar plan, the F.S.C.

A state by state survey of some of the difficulties encountered in the F.E.R.A. seems to indicate the difficulties that may be encountered in any system of state controlled medicine. One of the most common faults was the fact that Politics entered the picture too frequently. There was, in addition, a general argument about fees, and a general lack of knowledge and agreements about fees. This is to be met with in any system in which the laity attempts to adjust fees without a thorough knowledge of the amounts of fees to be asked. Couple this with the idea that no professional man has any real desire for anyone to tell him how much his services are worth, and to fix a definite price for each illness, so quite naturally a disagreement follows.

This same type of disagreement has occurred with fixed fee schedules for Workman's Compensation, even though the physicians had some hand in adjusting the amounts of the fees. Another fault found with this system was the fact that social workers were not well enough trained to efficiently handle many of the problems that arose. This same criticism could be made of the administrative department. With this in mind, it was found that in some localities only about 30% of those applying for and receiving charity should have been on relief at all. Other difficulties arising were laid to the fact that funds appropriated for medicine and services were shunted into other channels of relief and were not available when sorely needed. In many cases, too, it was found that the system was operated on insufficient funds resulting in a definite diminution of adequate care. There was also a general lack of knowledge for the necessity of treatment which resulted in inefficient care.

There were several faults found with the medical profession in several localities. One of these was that the physicians were making excessive and unnecessary calls. There were reports of over charging as well as the usurping of the duties of the administrative department. Unsatisfactory work was reported by the administrative staff. Here again comes the old argument against this type of system which is due to paper work. The efficiency of the physician is impaired. As one would expect, the personality

of the physician often clashed with personalities of the administration. The commissioners were accused of being too arrogant in many cases, while the physicians were accused of being too individualistic in comparison to the more social minded "collectivistic" attitudes of the administration.

One of the more important details uncovered was the fact that facilities for the care of the chronic cases were not adequate, especially in the rural districts where there seemed to be an inadequate amount of hospitals. Another problem arose, namely, that some of the individuals who needed medicine were unable to get it, particularly if the medicines were expensive. This, in the case of insulin, was, of course, disastrous and resulted in the wasting of much money on the treatment of diabetic coma instead of supplying insulin to the balanced diabetic.

With this experiment, we can visualize how a system of this nature can function. With this experimentation, we can see what steps need be taken in the future in order to remove as many difficulties as possible.. It is inconceivable that all disagreement can be ironed out. Looked at in an impersonal way, and it will be seen that the physician was aided financially in his work. As a general rule, however, one can scarcely say that the majority of physicians desire such a plan as this. One can scarcely say that this system was of unquestioned benefit to public health. It is not inconceivable that

the indigents would have been taken care of without such a plan. Suffice it to say that the plan was of government origin, voluntary in nature, and is still used in much the original manner under the Farm Securities Administration.(13) The preceding state by state survey was abstracted from numerous state medical journals.(14)

Here, then, are some of the observations of a positive nature deduced from this experiment. The plan must be small enough to fit the locality and should not in many cases be statewide. Generally, the small cities and towns are most benefitted. Systems of salaried phyicians seem to be much inferior as to personell and service as compared with this system(FERA). There seems to be less friction when the medical profession has complete control over and responsibility for medical services, and when all activities are based on a definite and fair agreement between all parties. The fact that the patient-physician relationship is not disturbed seems to make for better services, although, in this system, possibilities were not remote for interference from a third party. It was in those cases where the third party was well trained and realized the problems involved that this interference was reduced to a minimum.(14) In all events, this step may be looked upon as a necessary and experimental measure inasmuch as it did not abolish many of the concepts of the present system and did not become a permanent thing.

O.E. Locken, MD, in an address before the County Commissioners Conference in Minnesota, summarized recommendations for this type of service quite admirably. These recommendations were: (15)

1. Medical care of the indigent should be supplied by all of the doctors in the locality and not by contract with any one individual.

2. The individual patient should be allowed the free choice of physician wherever it is reasonably possible for him to do so.

3. A fair and equitable fee basis should be arranged for the payment of services rendered. It should be arranged by mutual agreement between the county commissioners and the physicians who give the service.

So much for the present day concept of giving medical care to the indigent by collaboration with the government. This type of plan is dependent upon the willingness of the physician and governmental agencies to work together efficiently.

There are other schemes designed for the care of those who cannot "afford" adequate medical care. Among the schemes most widely used abroad is Compulsory Sickness Insurance. Before going into discussion of this type of plan let us briefly evaluate it. Does this insurance promote a better public health? Does it decrease mortality and lower morbidity? Does it take care of chronic diseases? Does it exercise good preventative measures?

Any system considered as a substitute for our present system should be looked at carefully and all of the above questions answered carefully. With these ques-

tions in mind, let us review some of the older European systems of insurance. In the first place let us ask ourselves this question - Why have England, Germany, and Austria ceased to attract our physicians? Could it be for the reason that, under our free system, medicine has progressed more rapidly than under the state controlled systems of Europe? America today occupies the place in medicine that was once occupied by Germany, England and Austria. Today the few physicians, from those countries, that can afford it come to the United States.

Now let us answer those other questions. The first of these was - Does the system decrease mortality and morbidity? This can best be answered by reviewing the average number of days of sickness in the various countries. In the United States this amounts to from 7 - 9 days per year per person. It is nearly twice this in the insured group in Great Britian and Germany and has nearly doubled since the advent of insurance.(16) The Health Section of the League of Nations reports that six countries in 1934 had a death rate from all causes of less than ten per thousand. These countries were; The Union of South Africa, Canada, Australia, New Zealand, Norway and The Netherlands. Four of these six do not have sickness insurance. According to the same report, our death rate in 1934 was eleven per thousand, and includes the colored population of the South which is not found in any other country mentioned above. In 1939 and 1940 it is safe to say that the United States

is the leader with a low rate of 10.5 per thousand. Another example of contiguous countries in South America runs as follows; Chili has compulsory insurance and its death rate in 1934 was 26.8 per thousand, Argentina and Uruguay, who have no form of insurance medicine, have a rate of 11.8 and 10.0 per thousand, respectively. I feel that we can be perfectly just in saying that Compulsory Sickness Insurance does not seem to be associated with decreasing mortality and morbidity rates.

Does the system adequately handle preventative measures and does it control contagious diseases? There are certain types of diseases which seem to indicate, fairly accurately, the quality of medical service within that area. The two most important of these are Diphtheria and Tuberculosis. It is surprising that the United States, in 1934, had no city, save New Orleans, in which the mortality was more than six per one hundred thousand. New Orleans had 6.2 . This is the record of the United States. The German record is not so pleasing because 52 German cities in 1934 had a mortality of 11.6 per one hundred thousand. England was even worse with 121 cities having a mortality of 11.6 per one hundred thousand.(17) Tuberculosis presents much the same picture. Both diseases in both England and Germany at the present time are just holding their own with but a slight increase. We may conclude, that systems just reviewed are not of the best, at least are not in the same level of efficiency as this

country. Now that we have answered all the questions, we may proceed to a further discussion of insurance as found in those countries.

Why were these systems adopted in England and Germany? In both countries, sickness insurance was merely a political sop for labor. It was inaugurated by a labor government and has never been abolished. Bismarck, who inaugurated the system in Germany was forced into it by labor. Lloyd George in England was compelled to adopt a similar insurance plan. The system worked admirably as far as its original motive was concerned. It did placate labor. Unfortunately, it did more than that, however.

The English system of insurance seemed outwardly successful in the scope for which it was intended. It was certainly much better than the old club practice, and it did help to relieve the effects of poverty. It raised the effective income of the worker, but it was short on preventative measures. (18)

One argument used for compulsory sickness insurnace is that it is cheaper than our present system. Suppose that we were interested in cost rather than equality. With this in mind, let us review the German costs with the medical costs of the United States. In Germany, they say, the average cost per family per year is about six dollars. (19) Figured on a percent of income basis, we find in Germany that 1.7% of the workers income is

spent for insurance. The noninsured, we find, spend 1.5% of their income for medical services. (30) This, then, begins to show that perhaps the insurance plan is not as cheap as was originally thought. The total deduction in the German system amounts to 8.5% of the worker's wages, while the employer gives another 5% of the worker's wages to the fund. From this fund, sickness insurance as well as invalidity insurance, accident, and unemployment insurance is administered. (31) Taking into considered the employer's contribution of about 1% that is absorbed directly by the sickness insurance, we find an amount corresponding to about 3% of the worker's wages, when all sources of payment are considered. When we consider that the uninsured pay just one-half of this amount, we get still a better idea of the costs of insurance. Our medical costs average about 4% of the annual income which surely is not high when one considers the higher cost of quality and the decreased amount of disease found in this country or compared with Germany. (32) The point in favor of compulsory insurance, that it spreads the costs of medical care, can not be met by the above argument. Then, too, we must remember that price without quality means but little. It is a surprising fact that in Germany there is a sum of eighty million dollars spent on a class of people who in this country is largely taken care of gratuitously. (33)

Another difficulty encountered in a sustem of

insurance seems to be an increased demand for services. For example reports of the German system indicate that those who would call on the physician even if they had to pay for services themselves, amount to 30% of the total seeking services. We may conclude, therefore, that the 30% is that group in which medical care is necessary. Another group of 65% have such minor defects that they would come to the physician only if they were able to afford all luxuries. This 65%, then, uses the services given by the insurance plan only because it is available to them at no additional cost. The remaining 5% are definite malingers. Thus, one can readily see that with this system available people make far too many demands for treatment. In their demand for treatment there are a surprising number who literally recommend their own treatment to the physician, and literally write their own prescription. This is substantiated by the fact that all roentgenograms used in insurance work in Germany were not, clinically speaking, at all necessary. Of all the roentgenograms taken, only 35% were found to have diagnostic significance. (24)

There is yet another factor which has arisen in this type of system that has become quite a problem. There are some people who may go to an insurance doctor and are refused treatment because it is unnecessary . The doctor may refuse medication because that also may be unnecessary. Under a plan of insurance in which there is freedom of the choice of doctors, the patient may go elsewhere, and the doctor, who, because he needs another patient on his panel,

may give him the treatment and medication he desires. This is a common procedure in any system in which the benefits received are not dependent upon cost. If the person were paying full cost out of his own income, he would be loath to seek other advice merely for the satisfaction of receiving medicine.

In England, other peculiarities of the system have arisen. An example of this is the fact that six hundred thousand people who have paid for their insurance do not use it. They prefer the private physician. It is interesting to note that fully one-half of the people taken care of in the London free clinics belong to the insurance group. This gives us a fleeting impression that a good many people do not desire the insurance groups. The British Ministry of Health points out that the average number of insured persons for each family physician is slightly more than one thousand. For each patient, the doctor gets $3.50 a year, thus making a yearly average income of $3500. After deducting 33% for taxes, the physician is left an amount averaging about $1600 from which office expenses and living expenses must be deducted. Under a set-up of this kind, some physicians will have as high as twenty-five hundred patients while others will have approximately five hundred patients. (35) The doctor with the five hundred patients will very likely starve, while the one with twenty-five hundred is scarcely able to give adequate service to all. This very fact has been used as an argument against our own system, namely --one

doctor starves while the other makes a good living. It may be surprising to those who argue in this vein that the insurance doctor can also starve, economically, and educationally.

In spite of its many defects as pointed out above, compulsory insurance was at one time an absolute necessity politically and economically. It increased the effective income of the wage earner and reduced poverty. It helped spread the cost of illnesses. But---a system born of an emergency should gradually be withdrawn with the passing of the emergency. The difficulty in the British system and others is that politics prevents that withdrawal. In England, the Approved Societies who handle the insurance are much too strong politically. (16) It is well known that bureaus are good political investments and that bureaucracies can only be maintained by progressive and extensive expansion. If this statement can be kept thoroughly in mind, our lesson on compulsory insurance will be sufficiently well learned.

Voluntary insurance, as compared to the compulsory forms, has but few faults. Voluntary insurance carried by private companies, and with a cash benefit, will result in the abolition of catastrophic illnesses. It is not conducive to neuroses, and imbues a sense of thrift and responsibility in the individual. Private practice is removed from rigid political control. It is most useful in the class who cannot seem to budget for illness because their income is incompatible with

luxuries they desire and the amounts which they will sooner or later need for sickness. Voluntary sickness insurance, with a cash basis and free choice of physician, is the one manner in which the near indigent may prevent serious loss through "catastrophic" illness. It may be wise to say at this point that a Voluntary system almost invariably precedes a compulsory plan and that the indigent cannot be taken care of by this type of plan.

Another type of plan evolved for the individuals who may be unable to afford adequate hospitalization, or any hospitalization, is a plan of Hospitalization Insurance. It can readily be seen that those who are able to belong to this group and who can afford this type of plan are not indigents, although a goodly number who can participate in this system can be classified as indigents. The cost of participating seems ridiculously low when one considers the the cost of hospitalization without the aid of insurance. The scheme, therefore, is useful in certain of the lower income brackets and protects many individuals from the possibility of becoming indigents.

A trend toward this type of planning and a need for it is shown in a recent survey by Wilson J. Smillie, who made a survey in Rochester, New York, in January, 1941. This survey shows the following trends; (26)

1. An increase of hospital costs due to an increase in demand for hospital bed care.

2. Increased cost of hospitalization due, largely, to better and more expensive facilities.

3. A change in the type of demand, particularly in the demand for hospitalization of chronic diseases due to an aging of the population.

4. An extraordinary increase in hospital insurance.

Dr. Smillie found that the physicians recognized the fol - lowing needs ;

1. More low cost beds for private patients.

2. Better provisions for psychiatric care in general hospitals, and an additional better psychiatric out-patient department.

3. More beds for the chronic sick, especially for the arthritis and cardiac cases.

4. More facilities for convalescents and particularly for mental and dental care.

To continue with this survey, we find that people in general desired some form of insurance, but when this desire was analyzed only few could afford it. The " theoretical potential market" for such insurance seems to be about 17% of the total population. The conclusions that can be drawn from this survey are that there is some need for this type of plan although but a small portion of the population are able to afford it.

Economically, on an actuarial basis, the scheme is sound. It maintains free choice of physician and also maintains the patient - physician relationship, which is so important. It is not conducive to neuroses and it is designed, primarily, for the catastrophic illness. It provides a voluntary method of budgeting. It is of decided benefit in those borderline cases which would fall on charit y when hospitalization is necessary. The private hospitals would be benefited by an increase in population and the

physician would be benefited in a measure at least by having the hospital bill removed from a financial consideration.

The plans, over the country, vary greatly as to contracts for hospitalization. The maximum period of hospitalization varies as does the additional cost to the patient for time spent over and above the specified duration of stay. Most plans find that only 4% of the patients require a full three weeks stay in the hospital. In the large number of plans, therefor, a three weeks stay is considered sufficient. Some plans give service after the three weeks stay but at 10% of cost and bar chronic cases. Dependents can be hospitalized on a partial payment basis.(37)

In using a plan of this type it is wise to observe several precautions. The group, included in this insurance, must be a reasonably fair cross section of the population and the plan must be on a sound actuarial basis similar to modern life insurance plans. (38) All hospitals in the area should be included and the hospitals should only be a facility for the rendering of medical services and should never attempt to take the physicians place by hiring resident physicians to do the work. The patient - physician relationship should never be disturbed by the hospital.(38) Admission to the hospital should be secured only through the patients own physician. (39) This last statement may cause trouble

in those instances where the physician might not be on the staff of the hospital. This plan, if practiced, would do much to eliminate the serious illness as an economic fac - tor and indirectly decrease the cost of gratuitous service, thus increasing the coverage of free service to the indi - gents. (30)

Another form of prepayment plan for medical care is that of group or contract practice. It is very similar in nature to the insurance plans but in this type of plan the "company" provides the medical care and hospitalization in many cases. Herein lies the evil of this plan. It has one thing in common with the insurance plan in that it helps spread the cost of medical care. The saving under a plan of contract practice is not as great as will be shown later.

The extent of group practice may best be illus - trated by quoting Dr. R.J. Leland, M.D. who says that about five hundred plans are in operation. These plans may be divided into several types. There are now about three hun- dred and fifty group medical plans; at least twenty-four union sick benefit plans, and probaoly three hundred and fifty rural medical plans which are being sponsered by the Farm Security Administration." (31)

It would be an impossibility to discuss each plan, or even one plan in detail in this type of paper. We will limit the discussion of this type of plan to a general outline. In the first place, a plan of this nature

has a staff of physicians. The number is variable. A plan of this kind must have its clientele who pay a specified sum at a specified interval for a specified time for medical services, which may or may not include hospitalization. This group may have been initiated by the physicians themselves or by a lay group. To carry on this type of practice, it is essential that the group have adequate facilities and finances to carry on with adequate medical care.

Having set up this outline of a plan, let us now examine it to see where its defects might lie. In a plan such as this, it is obvious that there is but one variable. That is, the amount of medical care given or hospitalization, if it is included in the plan. Let us suppose, now, that the financial arrangements have been inadequate. It is obvious that the amount of service given will have to be decreased. An illustration of this may be found in a system which has recently been prominently displayed in legal circles. Dr. Richard B. Price, M.D., who was formerly a member of this organization, says, "I should say that nearly a hundred patients had been promised operations, and were not given them during that time. I believe the chief reason they were not given them was because the organization did not feel they had the money to pay for the hospitalization, and so forth. In other words, they were running---." (32) There are other cases which have been used to prove the same thing. One of these is the old case where a man's arm was amputated rather than go through the long period of hospitalization necessary to save it. We can not say this for

all systems such as this, but we can say that in instances where these systems were organized for financial purposes, finances often stand in the way of good medicine. This is only one of the faults.

Another fault in this type of medical care is one of faulty reasoning by its proponents. What is one of the greatest problems facing the medical profession today? One would not be far off to answer by saying that the care of the medical indigent is probably one of the greatest. Where does this plan solve the problem? Surely it doesn't make any plans for the indigent who is unable to pay. Plans such as the Group Health Association for example, take care of people who are in the comfort level of income. The more widely this type of plan is used, the fewer physicians will be left for the indigents, and the physicians will have fewer patients over and above the indigent group. The only logical solution remaining therefore, would be to put the remaining physicians on a salary basis, supported by taxation. What do we have? Socialized Medicine!

Let us suppose that any lay group is given, by law, the prerogative to evolve a plan of this sort. The board of trustees, or whoever administrates the system, has selected a staff of physicians necessary to carry out the service. Now they need patients, or subscribers. How are they going to get them? The patients will not flock to this new "clinic". The subscribers, a large part at least, will be obtained by maybe advertising or solicitation. It is

conceivable that no one will be able to tell to what extent this advertising may go, or what falsifications may be used to attract customers. We have several examples of this today in which even radio stations have been purchased so that a controlled output of advertising may be obtained. If one douots the efficiency of this advertising, one should read the story again of one Dr. Brinkely. This example alone snould deter one from adopting a plan which may be conducive to this sort of thing, or at least, if nothing else, make provisions for it, if possible. There have been other examples of this type of advertising sponsored by newspapers who, for the sum of one dollar, and a subscription to their paper, will assure you of medical care at half the usual cost given by their group of physicians. (32) Let us be fair and say that not all of these plans will stoop to this sort of advertising. Operated and controlled by the physicians themselves who adhere to their ethical standards, the likelihood is that no such thing as stated above will occur.

A survey made by the Bureau of Economics of the American Medical Association, who got its information from one hundred and forty-seven secretaries of the County Medical Associations scattered throughout the country, found; "It would seem quite clear that the individual physicians controlling the groups, have not generally succeeded in reducing the costs of medical care. They have increased in some cases, reduced it in others, and given better service for the same money sometimes, and unnecessary service at other times,

just as individual practitioners have done." One can readily see that criticism of this type of system cannot be made generally. Many groups have just as many different types of payments. Some groups have a minimum charge which includes laboratory and physical examinations, and extra payments for additional services. This type of system differs little from the scheme of the individual practitioner. (34) The contract practice which claims to give all types of service for a sum fixed by contract, may find that it cannot afford to give the services for the amount of money taken in. It is, therefore, common practice in this type of plan to charge a more than adequate fee to begin with. It is in this type of scheme that one more often finds medical costs being increased. This is due to the fact that the lay parties involved, and there must be several to administer a plan of this type, have to draw their salaries, too. Thus, the patients money will not be used one hundred per cent for services, but rather will have a percentage deducted for managerial costs. Take, for example, the much "maligned" Group Health Association, who would charge from three to four dollars monthly for complete medical services. This would run in the neighborhood of thirty-six to forty-eight dollars a year. (35) This does not show well by comparison with average cost of medical care in the comparable income group, as shown by the Committee On Costs of Medical Care. The average cost per person per year in the $3000 income class is $31.80, as previously mentioned. In comparison with the quality of service, the Group Health Association left much to be desired. Let no one say that a plan of this type will

invariably reduce costs. It stands a better chance of reducing the qulaity of service, especially so if the group is money-conscious, as so many are.

To summarize group practice, we find that its advantages lie in the inherent qualities of the physicians composing it. Its bad faults may be said to be inversly proportional to the amount of lay control of this group. If the group is administrated by the physicians themselves, then the faults are minimal and correspond to the faults of the individual practitioner. Too much cannot be said about schemes inaugarated by the laity, the misinformed individuals who have little or no conception of the ethics of the medical profession, or the peculiarities of medical services. To this type, medicine seems to be just a business. It is this type of plan which is fundementally dangerous, moreso now that the American Medical Association has no control over these individuals. This is another obstacle for the medical profession to overcome.

CONCLUSION

The purpose of this thesis has been to show some of the plans evolved in the attempt to give medical service. The indigent was considered, but briefly. The underlying thought was to consider the plans evolved because of the presence of the indigent group. These plans have been, more or less, the natural trend. Where they will lead, no one knows. It is not inconceivable that medical practice as we have known it may disappear, and another type of system will take its place.

In the beginning of this thesis, I attempted to show why there was a tendency for this change. I attempted to show that there was a need for active steps. This need was not present because of an inadequate system, but because economic conditions have changed as have the political conditions. The economists, the politicians, and the socialists have created a need. Unemployment has created a need. Some of the people themselves have created a need. Some maintain that this need requires a change in the system. I have attempted to prove in this paper that the need requires no fundemental change in the system that such changes, as contemplated, will destroy a system that has functioned and will function efficiently. This, however, will be true only if those who have failed in their fields will refrain from dabbling in ours.

The second part of this thesis was written in the attempt to evaluate the type of literature used by the

opposition of the present system. I wrote that the proponents of change made surveys and gathered statistics without a clear cut knowledge of the significance of the facts which they gathered. These facts, many of which are worthless, were used with careless abandon, or more correctly, maybe, with a prejudiced viewpoint. The Medical Association, in opposition to these writers, has their own fact finding bureaus. While some may consider this source of material as being prejudiced, also they cannot deny that a more than fair attempt has been made to present both sides of the question.

For the body of the thesis, I first presented an outline of the four possible methods of approach to the problem. This man, Sydenstricker, is one of the main cogs of the Milbank Foundation, which is a veritable bee-hive of socialized medicine. This man, who has done a good deal of study of systems abroad and in this country, agrees that public medicine, such as is practiced in Russia, cannot be used in this country for long. He also states specifically that medical practice along industrial lines seems wholly inadequate. Two other approaches remain. One of these is compulsory insurance. I have showed that compulsory insurance will not solve our problem. It does not, and can not, take care of the medical indigent. It lowers the quality of the profession. It does not practice good preventative medicine. By no facts or figures can anyone show that compulsory sickness insurance has accomplished anything from the medical viewpoint.

Economically and politically it accomplishes its purposes, but the quality of medical service under this scheme has never, and probably never will, recover from the blow.

What remains? What we have today is what remains to be considered. What the Medical Association does today will result in the system of tomorrow. We are on the brink. We are but a step from socialized, completely socialized, medicine. Some of the plans in vogue today may result in any kind of an undesirable plan due largely too a political pressure. As long as the physicians themselves can ascertain the method of approach to the problem, and avoid the pitfalls, the present system will remain intact, at least fundamentally.

Very recently the Medical Association has been deprived of their prerogative, if it can be called that, of over-seeing the type of medical care and its quality, that is given to the public. This is not fatal to the organization, but will require a more positive and united plan. What, then, shall we say our plan is? It certainly cannot be a defensive plan, because that can gain no ground. One attribute the plan must have is postitivness. The medical profession must at all costs, as they have in the past, give service to all who need it. They must remember in the future that propaganda is not without its virtues, and though seemingly innocuous, may be the strongest of weapons. Whatever the plan eventually evolved happens to be, the quality, and not quantity and costs should always be considered.

Bibliography

1. Bossard, James H. S.: "A Sociologist Looks at the Doctors," The Medical Profession and the Public, American Society of Political and Social Sciences, Philadelphia, 1934, Pp 71-75.

2. Parran, Thomas, Jr.; The Health Service of Tomorrow, ibid, Pp 75-87

3. Anderson, Elin: Do We Want Health? University off Nebraska College of Agriculture Extension Service, Extension Circular 1021, September, 1940, Pp 22-23.

4. Report of Clinic Held in Howard County, June 24-July 2, 1940, U. S. Department of Agriculture, Farm Security Administration.

5. An Introduction to Medical Economics, The Bureau of Medical Economics, A.M.A., Chicago, 1935, Pp. 56-59

6. Public Health Reports: Trend of Morbidity and Mortality in 1939 and Recent Preceding Years, Vol. 55, No. 19, Pp. 801-809.

7. Roche, Josephine: Medicine As A Public Health Function, Paper Given at the Annual Meeting of the American Public Health Association, New York City, October 5, 1937.

8. Foster, William T.: The Radio Debate on State Medicine, Reprinted with Modifications from the A.M.A. Bulletin, November, 1935, P. 4.

9. An Introduction to Medical Economics, The Bureau of Medical Economics, A.M.A., Chicago, 1935, Table 9, P. 51.

10. Sydenstricker, Edgar: Medical Practice and Public Needs, The Medical Profession and the Public, American Society of Political and Social Science, Philadelphia, 1934, Pp. 22.

11. Ibid, Pp. 26-28.

12. McNeal, John R.: Clinical Medicine and Surgery, March, 1935, Abstracted from Dr. R. W. Fouts' Article Read to an Insurance Group

13. Report of Farm Security Administration Committee, Nebrask State Journal of Medicine, 26:4, April, 1941, Pp. 155-56.

14. Care of the Indigent Sick, Bureau of Medical Economics, A.M.A., Chicago, Pp. 56-118.

15. Locken, O. E.: Medical Care for the Indigent, Address Given before the County Commissioners' Conference, Minnesota, February 28, 1936, Reviewed by Minnesota Medical Association, February 28, 1936.

16.J.A.M.A.; 104:1845, (April 6,) 1935.

17.Ibid. 104:1335, (April 13) 1935.

18.Alabaster, G.H.: State Insurance against Sickness, J.M.A. South Africa, 3:613 (Nov. 9) 1929, abstracted in The Handbook of Sickness Insurance, State Medicine and Cost of Medical Care, Bureau of Med. Econ., AMA.

19.An Introduction to Medical Economics, The Bureau of Medical Economics, AMA, Chicago, 1935, P.90.

20.Rink, W.: Review of Opinions on Relations between Physicians and Sickness Funds, Deutsche Med. Wchnschr. 56:896 (May 23) 1929.

21.Winslow, C. and E.A.:Some Reflections on Sickness Insurance in Germany and Austria, New Engl. JM, 200:1161.

22.Falk,I.S.; Klem, Margaret C.and Sinai, Nathan: The Incidence of Illness and the Reciept and Costs of Medical Care Among Representative Family Groups, Publication of the Committee on the Costs of Medical Care, no. 26, Chicago, Univ. of Chicago Press. Jan. 1933 Table 30, P. 151.

23.Winslow, C. and E.A.: Ibid.

24.Baeumer, Waldemar: Sickness Insurance now a Curse,Transformed a Blessing for the People, Munich, J.F. Lehman, 1930 taken from the Handbook of Sickness Insurance, State Medicine, and Cost of Medical Care.

25.Fouts R.W.: paper delivered before an insurance group Sept. 1939.

26.J.A.M.A.; 116:1146, (March 15) 1941.

27.Van Dyk, Frank: A Working Plan, American Medicine, Oct.1935

28.Introduction to Medical Economics, Ibid. P.83-86

29.Mills, Alden B.:Groups Hospitalization and Hospitals, American Medicine, Oct. 1935.

30.Roren, C.Rufus:Group Hospitalization,Amer. Med. Oct.1935

31.Leland, R.G.:The AMA on Trial,J.A.M.A., 116:1656,(Apr. 12) 1941

32.Price, Richard B.:The AMA on Trial, Ibid. p.1661.

33.Leland, R.G.:Contract Practice, pamphlet reprinted from J.A.M.A., Chicago, 1935. P.12-13.

34. Group Practice, Reprinted from the J.A.M.A., May 20, 193 3, 100:1605; May 27 1933, 100:1693-1699; June 3 1933 100:1773-1778. Bureau of Med. Economics, Chicago. P. 9.

35. J.A.M.A., 116:759, Feb. 22 1941.